* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Local No. 97 – 387

State No. 013902

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1. DECEASED—NAME (First, Middle, Last): JAMES PAUL FIELDS
2. SEX: Male
3a. TIME OF DEATH: 6:30 AM
3b. DATE OF DEATH (Month, Day, Yr.): April 10, 1997
5a. AGE—Last Birthday (Years): 75
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Aug. 2, 1921
7. BIRTHPLACE (City and State or Foreign Country): Muncie, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Ball Memorial Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Muncie
9d. COUNTY OF DEATH: Delaware
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Phyllis Dick
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Manager
12b. KIND OF BUSINESS/INDUSTRY: Manufacturing Engineer
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Delaware
13c. CITY, TOWN, OR LOCATION: Yorktown
13d. STREET AND NUMBER: 8408 W. Fairview Dr.
13e. ZIP CODE: 47396
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): 4

**PARENTS**

18. FATHER'S NAME (First, Middle, Last): James Paul Fields
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lizzie Shaner

**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): Jackie Jones
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8408 W. Fairview Dr., Muncie, IN 47396
20c. Relationship: Daughter

**DISPOSITION**

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 12, 1997 Elm Ridge Cemetery
21c. LOCATION—City or Town, State: Muncie, Indiana
22a. EMBALMER'S NAME: Anthoney Terry
22b. EMBALMER'S LICENSE NO.: FDO 9200050
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Gordon Cox
24b. LICENSE NUMBER (of Licensee): FDO 1006201
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: The Meeks Mortuary 3004918, 415 E. Washington, Muncie, IN 47305

**CAUSE OF DEATH**

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Ruptured abdominal aneurysm
DUE TO (OR AS A CONSEQUENCE OF):
b. Malnutrition, cachexia — > 5 years

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

DUE TO (OR AS A CONSEQUENCE OF):
c. history of cancer of Esophagus
DUE TO (OR AS A CONSEQUENCE OF):
d. Chronic lung Disease

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

**CERTIFIER**

29a. CERTIFIER (Check only one)
[X] CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
[ ] HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated.
[ ] CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John P Durbin MD
29c. MEDICAL LICENSE NO.: 01028322
29d. DATE SIGNED (Month, Day, Year): 4-11-97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): John Durbin, M.D., 2525 W. University Ave., Muncie, IN 47303

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE: Donna A. Wilkins MD
32. DATE FILED (Month, Day, Year): APR 11 1997

33. MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
34a. DATE OF INJURY (Month, Day, Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no):
34d. DESCRIBE HOW INJURY OCCURRED:
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify):
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.